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The Honourable MaryAnn Mihychuk

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● (1530)

[English]

The Chair (Hon. MaryAnn Mihychuk (Kilo[illegible]—St. Paul, Lib.)): Welcome, everybody. Let's get the meeting going.

We are at the indigenous and northern affairs committee of Canada. Pursuant to Standing Order 108(2), we are conducting a study of long-term care on reserve.

We are actually meeting on the unceded territory of the Algonquin people, a process we always recognize because we have really, I think, sincerely started the process of understanding, recognizing truths, and moving to reconciliation. It's a bit slow in our process of history, but it's always good that we're here.

Presenters will have 10 minutes. When the presentations are done, we will allow for questioning, and that will take up the full hour.

We have Dakota, File Hills, and then Driftpile.

We have three presentations.

We're going to start with Dakota Oyate Lodge. We have Della Mansoff, the director. She is all the way from the great province of Manitoba.

Welcome. You have 10 minutes. I'll give you a signal when you're getting close.

Ms. Della Mansoff (Director, Dakota Oyate Lodge): Thank you.

I'd like to thank the standing committee for the invitation to present today.

I have listened to some of the previous witnesses to have an idea of what was being presented, and not to say the same things that you've already heard.

I represent the Sioux Valley Dakota Nation. It is the only self-governing first nation in Manitoba, and they have a tripartite agreement for governance. We are in a unique situation. We're able to create our own laws and break a lot of the barriers that my colleagues here are still facing. These are quite difficult issues.

The Dakota Oyate Lodge is a 26-bed personal care home located within the community of Sioux Valley. We're half an hour from Brandon, which is a big city in Manitoba, even though people only know of Winnipeg. We have good access to services in our proximity to the main city and to the hospital, but you would never know we're there.

A lot of the issues we face are that we are still not part of the RHA, regional health authority, so we aren't given the same sort of latitude that the RHA personal care homes or long-term care facilities are given. We don't have the supports and services that the other long-term care facilities have that are just 15 minutes down the road. We don't get OT support, speech-language, dietitian services, rehab services, mental health services. We have to pay for all those things, whereas they are part of the RHA.

We have to pass Manitoba health standards. You have to meet 26 standards and about 500 points to be licensed as a personal care home in the province. Twenty months ago, we completed and passed our standards. For the last 20 months our licence has been sitting on the minister's desk to be signed. We've completed our framework agreement. Both the band and Manitoba Health have agreed to it. It's sitting on the minister's desk.

Without that licence being signed, we aren't able to take what are called level 4 people into our home. We have four levels of care in Manitoba. Level 1 is usually maintained in the home through the home care program. Level 2N, which means they have no behaviour issues, are also looked after by the home care program. Level 2Ys and 3Ys come into our care home. We aren't allowed to accept level 4s, those who are in most need.

We do have a young man in our home right now because it is his home community. He is paralyzed from the neck down due to a head injury. He came home to live in our care home. We have the only facility with bariatric-size rooms in the whole of Prairie Mountain Health, which encompasses a great part of southern Manitoba. This man comes with absolutely no funding. He can't get any assistance from anywhere. He's a man living at home, and he has no money coming in. He stays in our facility for free because he needs to be at home. He needs to be around his family, but because we aren't allowed to accept level 4s, we can't get funding for him. It's a despicable situation, in my mind.

When we speak today, I would ask you to think about your family. Put yourself in the situation. If you got injured today or if you have MS, cerebral palsy, a young child who is autistic, you're going to end up in our home because in a first nation community, there is nowhere else to go. Sioux Valley is embarking on a venture to increase the services around the long-term care process and the chronic care process by adding 12 independent living facilities that will be located on the same property as the long-term care facility.

With home care programs, there are not enough people and not enough money to do around-the-clock care or even evening care for most of the clients. We would reach out and do that from the care home. We're looking at breaking some barriers to change the process. Since we don't have to live within those agreements now, we can make the required changes that work best for the community.

● (1535)

We service only indigenous people. We have people from all the reserves around southwest Manitoba as well as eastern Saskatchewan. We have Dakota, Cree, and Ojibwa people all the time, so we are servicing that cultural piece.

We also do all the palliative care. There is no funding for it, no training for it, but as a nurse, you do what you have to do, and we do it.

We have residents who have critical wounds. As I'm sure most of you are aware, diabetes is so rampant that wounds become stage 4, which are extremely deep and difficult to deal with. We can't get proper dressing supplies. We basically have gauze, tape, and saline. To get the proper dressing supplies that we need, we have to fill out paperwork to send to first nations and Inuit health branch, and if they approve it, then we get it, but it's only for a certain amount of time and then we have to reapply and show the need and the cause, or we send the person out of the community to be treated in the city.

Again, at their worst, they're not allowed to be at home. As we all know, none of you would want to be shipped to Toronto if you couldn't be cared for in Ottawa. That just wouldn't cut it.

Dialysis service is another issue. We have service in Brandon, but we don't get transportation to take our people to dialysis because technically you are supposed to live within a half hour of the facility from which you are getting the treatment. Well, we do. In Sioux Valley we do live a half hour away, but they still don't see that as right. They expect everyone to move from their home in Sioux Valley to Brandon to be near the hospital. Dialysis treatment takes about three hours, three times a week, and for the rest of the time patients are supposed to live in a city where their families may or may not be able to come to visit on a regular basis.

Our residents struggle with the ghosts of the past. We still have adults in there who have been through residential school and certainly the sixties scoop. All of these issues are still alive and well in their memories today. They have difficulty with care from non-indigenous people, and the women definitely don't want to have care from men. We have to do a lot of work around being culturally appropriate even in the world of today where a nurse is a nurse and if you're a health care aide, it doesn't matter if you are male or female, you do the work. However, we are very conscious of the culture and of making sure that our residents receive the care they are most suited to and are comfortable with.

A benefit of not being part of the RHA is that we we are able to work with our residents as their needs present. We do have the policies and we do have the rules that we have to follow because of standards, but at the same time, for our residents, it's very much central that they come first.

Just to wrap up, I'm very honoured to be here. This is a nice step in going forward and at least understanding what is happening out there.

When anyone is in Manitoba, please come and visit us.

The Chair: Thank you.

Our second presenters are from File Hills Qu'Appelle Tribal Council. We have Chief Bellegarde and we have Gail....

Hi, Gail. Is it Boehme?

Ms. Gail Boehme (Executive Director, File Hills Qu'Appelle Tribal Council): That's pretty good.

The Chair: You're being very generous.

You have up to 10 minutes, and I'll give you a hint when we're getting close.

Chief Edmund Bellegarde (Tribal Chief, File Hills Qu'Appelle Tribal Council): Thank you, Madam Chair.

Good afternoon to the committee.

I appreciate the invitation to come and address you on one of the foundational and critical matters of quality of life, and that's public health care. That's an issue we take very seriously, and we are taking a lot of measures and a lot actions into our own hands to address some of the issues and the gaps that I'll talk about.

File Hills Qu'Appelle Tribal Council is located in Treaty No. 4 territory in Saskatchewan. Treaty No. 4 territory spreads throughout much of southern Saskatchewan into central west Manitoba, and tips into Alberta, up close to Medicine Hat. Treaty No. 4 was entered into in 1874. Our tribal council has 11 first nations. Nine are parties to Treaty No. 4 and two are not treaty parties. We have Cree, Soto, Nakoda, Dakota, and Lacota first nations as part of our tribal council. We are reforming our governing structures based on indigenous governance principles. We're reawakening that spirit of that alliance that existed on the great plains prior to Canada's existence and prior to contact from European nations. That confederacy model will continue to drive and bring forward our solutions and our legal and policy frameworks in a contemporary sense. That's the important work we're doing today.

We've forwarded a couple of reports on long-term care and some of the challenges. You'll see that all of the statistics and the indicators of health for indigenous people and on the indigenous population side, all of the problems, all of the challenges, in terms of access, the eligibility and ineligibility, the procedures, the different programs, the different ministries at a local, provincial, and federal level are symptoms of public policy and policy frameworks that are ineffective and, I will say, failing indigenous people.

When we look at health care, we see some of the international aspects of the United Nations Declaration on the Rights of Indigenous Peoples, which the House just had third reading on. There are two particular articles, articles 23 and 24, that address health care. The declaration itself is a framework for reconciliation for Canada and the first peoples of this territory. The Truth and Reconciliation Commission calls to action, specifically calls to action 18 to 24, address health care and all of these jurisdictional challenges.

There are challenges that are often exacerbated by ineffective policy stacked upon another ineffective policy, stacked yet again on another ineffective policy. Throw in disputes around jurisdiction between federal and provincial responsibilities and Indian people. Then you get into on-reserve and off-reserve eligibility, and ineligible aspects, the lack of compatibility across the policy framework when it comes to Indians and health care on reserve. There are many challenges, and the public policy frameworks are not compatibly designed between federal and provincial orders of government. You throw in these challenges, and access, and not being eligible or covered, it's like Jordan's principle 10 years ago, and that young first nations boy from northern Manitoba. Ten years later, we're still facing those policy challenges in those jurisdictional gaps between provincial and federal orders of government.

● (1540)

That's really what is precluding or determining poor outcomes for health for our people. It's really access to that care, that discriminatory practice that's maybe not meant in the policy frameworks, but those are the outcomes.

When we look at that, we look at it from our perspective. Health care is about dignity. Access to primary acute care services, to long-term care homes, that dignity of life and that caring for our people, is critical. What we're looking to do and what we're leading is indigenous-led policy frameworks, research that's indigenous-led under indigenous research methodologies. Those are our ontologies, our epistemologies. In short, those are our ways of knowing, our ways of sharing, our ways of speaking, our ways of analyzing when it comes to research. We have the All Nations Healing Hospital, an acute care facility that blends traditional healing, and our White Raven Healing Centre. We have community health and we have palliative care, all on a reserve, the Treaty 4 reserve right in the town of Fort Qu'Appelle in Saskatchewan.

This is a new public policy framework. We're just coming to our 14th anniversary of operating. Now we are starting to drive public policy. We are driving a new model of care in health care. We're driving ways, innovations on traditional medicines, traditional healing practices, our concepts of health care and access to it. We're dealing with those practical realities of trying to integrate on the foundations of public health care, acute care and community health, traditional healing and our ideologies around health care, our ways of knowing, our ways of healing, our ways of teaching this, our medicines, our natural medicines. There is the spiritual context of health, the mental context of health, and the emotional context of health. The western side is the physical side of health.

We're bringing models into a public debate, into a public policy space, that actually integrate and respect and bring forward the strengths of all of these aspects. Our hospital is a public hospital. We treat anyone and everyone who presents for care. We serve the local catchment area. It's pretty complex in terms of our funding. We are federally funded through Health Canada and the first nations and Inuit health branch. We are funded by now the Saskatchewan Health Authority. That's a regional health authority provincial model. We get different programs. There are many unique things that are happening in Fort Qu'Appelle at the All Nations Healing Hospital. We're an innovation site. We're leading public policy change by bringing practice, by bringing experience, by bringing data, by indigenous-led research.

In fact, we are working on a research project right now with the Johnson Shoyama Graduate School of Public Policy in Saskatchewan at the University of Regina and the University of Saskatchewan. It's about the Indian solution to the policy problem, developing an indigenous policy-making model to address first nations health disparities.

We're bringing solutions to strengthen public policy models in this country when it comes to indigenous health. We're taking down barriers. We're building bridges to close those gaps in jurisdictions. We figured it out through practice the last 14 years. How do we get the federal-provincial jurisdiction gaps closed? We're operating in between that space and we're operating very effectively.

We have had an exemplary accreditation standing with Accreditation Canada for the last eight years. We work hard at that because we know that we have to earn the confidence of the public that we serve, the town of Fort Qu'Appelle and the surrounding area. We work hard at that. The public is now seeing that new model of care in our women's health centre, the birthing units, the long-term care and our care of our elders. Those are our teachers and our professors.

● (1545)

We are bringing models to public policy. Public policy has to change.

I would leave this final statement to the committee and the hon. members here: Canada, it's time to create effective policy frameworks that serve indigenous interests and impact us.

Thank you.

● (1550)

The Chair: Thank you very much.

Now we're going to Alberta, and we have two people on our video conference, Florence Willier and Sandra Lamouche. You have 10 minutes to present.

Ms. Sandra Lamouche (Health Director, Treaty 8 First Nations of Alberta, Driftpile Cree Nation): Hi. I'm Sandra Lamouche. I'm the director of health for the Treaty 8 First Nations of Alberta, and with me is Florence Willier, who is a Driftpile First Nation council member.

Driftpile got an invitation to be a witness, and we're going to talk about something new. They actually do not have a long-term care facility in Driftpile, but they want to be a pilot location, and they have already started the research process.

The two folks who were just talking, who I believe are from Dakota and Fort Qu'Appelle hospital, represent the two systems we need to learn from. Dakota is facing challenges, and we see those challenges in Alberta as well with our health centres. It's something that we need to learn as a type of best practice, and we need to look at Fort Qu'Appelle's success story.

Driftpile is working in partnership with the Province of Alberta and the funding agency in the federal government to start a pilot project in continuing care for an elders lodge. The two will be working together, side by side, utilizing health services such as nursing through the health unit right in Driftpile, and will hopefully be building this facility near the health centre.

That's the project we're looking at, and Treaty 8 is helping out. We're the folks bringing the two parties together. That's my job.

Florence is sitting here, and I'm going to give her the floor for a bit to describe where they are with the project, and to describe her community in a little more detail.

Ms. Florence Willier (Councillor, Driftpile Cree Nation): Good afternoon, MaryAnn and committee members.

My name is Florence Willier. I am a member of the local government leadership. My community has about 1,050 to 1,100 people living on reserve and an equal amount living off reserve, for about 2,800 altogether.

I'm not sure if anybody has heard about Driftpile previous to this, but in our community we have a large population of diabetics and a large population of people who are over 55 years of age and are now in need of long-term care.

We have a health centre that is staffed with a nurse, and we do have a doctor that comes in weekly, but most of our people have to travel out for all the specialized care such as dialysis and long-term care. They have to leave the community and be housed in a provincial system. Right now in Treaty No. 8 near Driftpile, there is no long-term care facility we can access. There are provincial long-term care facilities with a huge waiting list. We are usually put at the bottom of the list.

Acquiring those services is a very lengthy process. A lot of times we have to seek other first nation long-term care facilities that are hours and miles away from Driftpile. People have to basically pack up and leave, and a lot of them end up dying in those facilities without coming back home.

One of the wishes of a lot of the elders is to die at home. It has been a pressing task and goal for the leadership to get this long-term care facility built on our nation's land to service the people, to get all those essential services that every Albertan and Canadian receives: OT, PT, speech and language, and dialysis. We have a large population of dialysis clients who have to travel out three times a week every day of the week.

We've always had a large dialysis population. A new hospital has been built 30 minutes away from us. The unfortunate part about it is that there is no dialysis in that brand new hospital, so again we have to travel out for that specialized care.

The greatest need for our community right now is the long-term care facility. We have 11 members who are accessing services miles away from home, as I've said, and we have at least an equal amount still waiting in our community to be put into long-term care.

● (1555)

We have completed a feasibility study. We are nearing our business plan and architectural plan, which is ready to be brought out. I guess our greatest task that we're trying to achieve is to go into a pilot project with the province. We have been working with Alberta Health Services, and we have been at the table numerous times. It is a very good working relationship, and we hope that we can continue working with Alberta Health Services and the province to make this a reality for Driftpile Cree Nation.

Meegwetch.

Ms. Sandra Lamouche: Thank you for listening. I think we went a bit over our time limit.

The Chair: There's a bit more time for questions, and then you'll have an opportunity to provide more detail through that process.

We're going to start with MP Danny Vandal.

Mr. Dan Vandal (Saint Boniface—Saint Vital, Lib.): Thank you very much for your presentations. They were very interesting. It's always nice to see a fellow Manitoban at the table. There are two of us on this side of the table, and Saskatchewan's close to Manitoba.

Let me start with a question for you, Della. You mentioned you're not a member of the RHA, the regional health authority. Is that because you don't want to be? Can you give me a little bit of context there?

Ms. Della Mansoff : For Sioux Valley, being on a first nation, the care is covered under the RHA, but in terms of a nursing facility or a long-term care facility, we would be maintained as a private facility, just like other allied facilities like Salvation Army's Dinsdale Home, Hillcrest Place, and Centre Park Lodges, those sorts of things. They're independent of the RHA.

Once we become licensed, then we would have a service purchase agreement with the RHA so that we can access more services, and we can be part of the long-term care network, leadership committees that the RHA has, their pharmacy and therapeutics committees, and things like those.

Right now, we're not even part of their panel process. When we have an admission come into the facility, we follow all the Manitoba Health rules and applications, but the RHA won't even review our applications.

● (1600)

Mr. Dan Vandal: You mentioned in your presentation that in terms of licensing, you've been waiting for 20 months. I believe you said your application was on the minister's desk. Is that the provincial minister?

Ms. Della Mansoff : Yes.

Mr. Dan Vandal: I assume you've called and you've made requests. What sort of response did you get?

Ms. Della Mansoff : They're just waiting. I'm not sure what his reason for not signing is, but it was.... He's getting to it. He apologizes for the delay.

We have met all the criteria. When they do a licensing visit, Manitoba Health sends out two representatives from Manitoba Health who come to the facility and spend, in this case, a day and a half reviewing charts, talking to residents, talking to staff, and looking at our evidence, and then they let us know what we pass or fail at.

They took some of our policies to use as training in other provincial homes across Manitoba.

Mr. Dan Vandal: Okay.

Ms. Della Mansoff : I wanted to hit the gold standard, and we went platinum with the work we did. In terms of that, when you're involved in this process, it took us three years. There are six other first nation personal care homes in Manitoba who have been working on this for more than 10 years, and they're trying to get close, but since the government changed, the initiative has not been respected.

Mr. Dan Vandal: You mentioned the other care homes in Manitoba. Do you communicate with them regularly?

Ms. Della Mansoff : Yes. I am part of the first nations personal care home network group. Until very recently, I was one of the co-chairs. We meet on a monthly basis. We work together on standards, and we work together on political issues like this, and wanting to be heard.

When this opportunity came forward, it was very timely, because we are really trying to push for people to hear our concerns and that we are being treated less than—

Mr. Dan Vandal: I understand.

I don't have a lot of time, so I'm going to move on.

Our Canadian Department of Indigenous Services provides home and community care through the first nations and Inuit home community care program.

Chief Bellegarde, are you familiar with this, and have you been working with them over the years?

Chief Edmund Bellegarde: Yes, we do deliver home care programs through our community health services, but there are still challenges. There are various ministries at a provincial level. Then there are different requirements or eligibility aspects and different perimeters around funding and what's eligible. It gets pretty complex in a very short period of time.

For an average citizen who is looking to access services, it becomes a challenge. There's a real need for navigation through the system, because you have stacked or tiered levels of service. Something might be ineligible for this, but it may be eligible to access it through a different program or even through a different jurisdiction, provincial versus federal. We're really challenged with that type of access.

Mr. Dan Vandal: If you were to give us a recommendation on how we could provide better service and amend what we're doing as a federal government, what would that recommendation be?

Chief Edmund Bellegarde: It would be to recognize our rights as indigenous peoples to lead the policy-making process and we will come forward with policy solutions that are much more effective in changing the long-term health indicators for our people. We'll do it because we understand our ways, but we're also experts on the public standards, because we have been forced to live with these for 150 years. We've been forced down this road. We operate in that space of federal and provincial public health standards through our acute-care hospital.

We already have the practice. We're starting to shape different models of care where the public—not only indigenous people, but now the public—is starting to access the care of traditional healers through our spiritual practice combined with western medicine. There are protocols between our traditional healers and our attending physicians and nursing staff. We're bringing models of care that are actually strengthening public policy overall, and not just for indigenous people.

● (1605)

The Chair: Thank you.

The questioning now moves to MP Cathy McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

Thank you to all the witnesses.

I want to make a few notes right up front. This is a really important study which, as far as I'm aware, the indigenous affairs committee has never undertaken before. As I look at the motion, it asked for a comprehensive study on long-term care on reserve—elder care, chronic illness, palliative and hospice, and culturally relevant practices. It's a massive study, and the committee is committed to look at this for only another meeting. It means three meetings in total.

I think this is really important, and we need to do a good job on this. I'd like to put forward a motion that we continue the study and extend it into the fall, and that a travel request be submitted in partnership with this initiative.

For us to do the work we need to do, we need to see places like the hospital you were talking about.

I would put that motion on the floor.

The Chair: MP Vandal.

Mr. Dan Vandal: Could I suggest that the motion be tabled until we do committee business? Then we could spend our time asking our witnesses the questions that we have.

Mrs. Cathy McLeod: I think it's a quick, easy one that hopefully will be supported.

The Chair: MP Bossio.

Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.): I totally respect the member's motion. Generally I'm in agreement with it, but I think it would be best for us to have a discussion.

Maybe we could get back to you in the next meeting.

Mrs. Cathy McLeod: I just want to have it on the record—

Mr. Mike Bossio: Sure.

Mrs. Cathy McLeod: —that I believe it's important, especially with health care moving from Health Canada to the new department and ultimately into first nations communities.

Chief Bellegarde, it sounded like you got through that maze of complications with the federal government and the provincial government, and representing the communities you represent, to create a hospital between you. Perhaps you could tell me a little bit more about that process and what the federal government needs to do. There's expertise in the provinces in this area, for sure. To be quite frank, I think the federal government doesn't have as much expertise in terms of health care or health care delivery. Apart from, as you say, trying to ensure that first nations assume responsibility for it, talk about your process and what we need to do.

Chief Edmund Bellegarde: It's a long story, so I'm going to try to keep it succinct.

On the issue of studies, the data is there. The data has been there for decades upon decades about health indicators and the challenges of the system, the access, the complexity, the jurisdictional divide. The data is already there. I would submit that action is required. You do have innovation sites around this country that can take action and can operate on a pilot project basis.

One issue, of course, is under-resourcing. This means budgets and some of those constraints, and cost-control restrictions. We understand those. We manage our processes very well from a fiscal management perspective. Our executive director and our executive team at the hospital have enabled us to set aside surpluses year over year so that we can invest in a capital project for dialysis services. We offer renal care.

Neither the federal government, nor the provincial ministry of health, nor the regional health structure wanted to support this. We couldn't get everybody together, so what we did was to make a long-term plan. The challenges to accessing services for renal care...the impacts of dialysis, renal care, and diabetes on our people are paramount, so we put a long-term plan and a strategy in place, and we backed it up with our own money.

We made a plan to build an expansion of our hospital in Fort Qu'appelle. We started that process. Health Canada and the first nations Inuit health branch came online very quickly because they know the work we're leading at the hospital. They know the model of care we're developing. They know that the data that's now being produced is starting to trend, not only for first nations people but for the public we serve. It's a matter of closing some of those gaps and trending in a positive way.

They knew that, but this separation, the division of powers between federal and provincial in health care, always limited what Health Canada and first nations and Inuit health branch could support. They couldn't support the actual delivery of a service—dialysis services in that renal care paradigm—because it would take them offside. They didn't want to set a precedent that may spill over into Manitoba or Ontario, and so forth, and provide health care service delivery funding to a hospital. Even though we're on reserve and are not under the auspices of the provincial health system, they didn't want to step into a precedence area.

The province told us, "Listen. We do this on data and on numbers, and our numbers are in the north, in the Prince Albert and Meadow Lake areas. There are higher needs in that area, so you're number two or number three on the list." We were always fighting to get ourselves as a priority because it was our people whose quality of life was impacted, our people who were giving up even trying to access service and primary health care because of these challenges. We put our money behind a long-term plan. We had the credibility. We could recruit our own physicians outside of the provincial health care physician recruitment strategy because that wasn't serving rural Saskatchewan either.

We took action. We put resources and our own money behind it. We didn't wait for approval from either the federal or provincial governing authorities. We're now weeks from offering full dialysis services with Saskatchewan Health Authority's support.

● (1610)

Mrs. Cathy McLeod: In British Columbia, for example, we have a hospital act under which hospitals have to be designated. You are designated under the hospital act but not under the health authority. How much does the province pay of your operating costs?

Chief Edmund Bellegarde: It's $6.9 million. We have health care initiatives with the first nations and Inuit health branch of Health Canada for some of the pilot projects, some of our women's health centres, and some of the innovations that we're leading. There's also the provincial system for acute care services and the funding for acute care. We have lab services. We have all the staffing costs of the nursing staff and capital costs. They're stacked agreements. There are always challenges between provincial and federal, so we balance as best we can. Where there's no leadership on either side, we'll take the lead and run with it.

The Chair: Questioning now goes to MP Rachel Blaney.

I remind members that we have three groups presenting, so please direct your questions accordingly. We have two members on video call.

Go ahead, Rachel.

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you, Madam Chair.

Thank you so much for being here.

I'm going to start with you, Chief Bellegarde, if that's all right.

I want to thank you, first of all, for bringing up [redacted] colleague's bill, Bill C-262, on UNDRIP. I think it's a fundamental principle that we need to be looking at.

One of the things I find very interesting about what you're telling us today is exactly what we should be moving forward in, which is changing the process in Canada because of the wisdom of the indigenous people who were here in the first place. It's that sort of changing process, and understanding that free, prior, and informed consent is a lot broader than just on energy processes.

One of the things you talked about really clearly here is that we have a framework where the policies are just piled on top of each other and they're not functioning at all. Yet you have applied a lot of wisdom and knowledge in figuring out how to bring these multi-jurisdictional areas together through your hospitals. Could you tell us a bit about what you could share with the federal government around that expertise?

Chief Edmund Bellegarde: There's the other level of policy framework in that legislative aspect, and that's what we're working hard on, on the indigenous side, through our first nations and our governance structures. We're bringing that forward.

It is true, there's the UN Declaration on the Rights of Indigenous Peoples; it is true there are the calls to action, but it really is self-governing, which the Sioux Valley Dakota Nation is on. We have the Whitecap Dakota nation, just south of Saskatoon, in their own self-governing negotiating process.

It's about empowering and enabling. It's about building institutional capacity, and we're investing not only money but also our people resources. We're accessing that traditional knowledge. We're interpreting our traditional knowledge from the languages, from our elders, and from our traditional healers; and we're making it so that it matches public standards, whether federal or provincial.

When we do that, we develop new models, policy frameworks that actually are more effective. Then when we infuse traditional knowledge and indigenous knowledge on traditional medicines in a more holistic model of care and health, it strengthens that public health care model and public health care framework. We add value to the policy, instead of federal-provincial and that's it: "You guys have to operate like this and under the auspices....." We've not accepted that. We want to provide better policy. We want to strengthen public policy. We want to bring solutions forward. We're doing that. We're practising that. We're leading that. We're researching that. We have the data. We're innovating.

Put some action to some innovation sites, and let's start to bring new policy frameworks forward that work in federal and provincial....

● (1615)

Ms. Rachel Blaney: You also mentioned something around Jordan's principle and the application, and you're not the first person to bring this up. We've really seen a focus on young people, which is so important. What we heard here is that it has to be broader than that, because that multi-jurisdictional issue is coming up not just for children but across the board. Of course, care has to be the priority. Could you talk a bit about the impact?

Chief Edmund Bellegarde: The impact of intergenerational trauma starts at an early age for too many of our young people. They carry that, and it impacts their health. It impacts the length of their lives. They're living a much higher-risk lifestyle. Their health standards, their nutrition, and their access are all subpar to the Canadian standard, to provincial standards.

It has to apply through that full spectrum. It has to be more holistic. If you are suffering trauma, whether emotional or mental, that's going to impact your health. That's going to impact those indicators.

We need to understand that Jordan's principle.... It's not necessarily just about young people. It's about a policy framework that is not working, that's ineffective in meeting the challenges or serving the needs and interests of the people it's supposed to serve.

Ms. Rachel Blaney: Another thing that you mentioned briefly is the reality of services for indigenous people both on and off reserve. I want to pull it out a bit more because I know it's a challenge in my community. Often people, even if they are not on reserve—I know it's true in my community—will go there to get the support they need. That is definitely one of the policy breakdowns.

I'm wondering if you could talk a bit about that policy challenge.

Chief Edmund Bellegarde: It's institutions that haven't been friendly to our people, like hospitals. The Fort Qu'Appelle Indian hospital was a place only for Indians back in the 1930s, and that transferred to the All Nations' Healing Hospital. That's what we've been working toward.

It's that institutional aversion, skepticism, or fear for our people; it's access. Some of the stats don't capture all the people falling through the jurisdictional cracks, because the system is overly complex. There's a lot of procedure and policy and paperwork to it, and they don't have all the navigation services or supports they need. When there's transition between reserve and off reserve, especially in more southern communities where that transient lifestyle is very prevalent, those are challenges. They get lost because, are they federal or provincial?

Piapot First Nation is 20 minutes from the city of Regina. There are a lot of transients and a lot of people falling through the cracks, and when people have barriers to access, they give up trying to access. Those people aren't even counted in the stats or the data that is driving some of the policy decisions and appropriations from the Treasury Board.

● (1620)

Ms. Rachel Blaney: Thank you.

Della, I only have a few seconds, but I can't figure out the barrier for the minister to get that application off his desk. You don't know what it is?

It's totally restricting your ability to provide things like rehab, occupational therapy, and so on.

Ms. Della Mansoff : It's restricting our ability to bring in level 4 residents, and have them paid for through Manitoba Health. That's the promise.

The Chair: Questioning is moving now to MP Will Amos.

Mr. William Amos (Pontiac, Lib.): Thank you, Madam Chair.

Thank you especially to our witnesses, both in town and on video.

I'm ignorant when it comes to matters of traditional healing. I don't know anything about its integration with a traditional western health care system, and I would love to learn more.

I think the average Canadian also has a similar degree of understanding as I do. They probably don't know very much, and I think it would be very helpful to have a broad explanation on the public record of how that integration is achieved, and what the future could look like, and maybe some variations on what it could look like because I can imagine traditional healing approaches will vary in some communities.

I was struck by your comment, Chief Bellegarde, and I'd love to give you an opportunity to give us that primer.

Chief Edmund Bellegarde: Thank you for that.

I changed my schedule to be here in person because health is paramount, especially long-term care, as it's a lot of our traditional knowledge from our elders, but it's also the system and the policy framework. I welcome any opportunity to share some of the work we're leading, some of the models we're developing and practising, some of the data we're collecting, the research we're leading, the methodologies, the ontologies, and the epistemologies—our ways of knowing and being—our traditional laws, our traditional healing practice, the medicines, how they're prepared, when they're picked, where they're gathered, the spiritual context of how they're used because there are different uses for the different plants and medicines that are gathered.

Much of western pharmacology and medicines are based on traditional knowledge of natural medicine. We're reawakening that aspect. We're just bringing that to the public policy discussion to remind western medicine that the foundation is through indigenous knowledge and natural processes for healing and medicines.

We're reminding Canada, but we're also reminding the world because we're in this together. We need to strengthen that entire loop, and if we can add value, that's where we are trying to insert ourselves.

We would welcome that opportunity to share the model and to share our wise practices that we've developed.

Mr. William Amos: Thank you.

Perhaps I'll invite our witnesses who are on video conference to share their experience in the areas of traditional knowledge or if, in the practice group within the institution they work in, there is that kind of approach to engaging traditional healing. Perhaps you could give us a specific example of how traditional healing might be incorporated into the long-term care context.

Ms. Florence Willier: We most definitely, through our health centre, have utilized traditional healers along with western healing practices. The doctors who come into our community have been very open to learning from the traditional healers. Our people live by the medicines that are picked yearly. They practise what has been taught to them when they were younger. We need to keep carrying forward those teachings, to preserve our way of living, to preserve those natural healing practices that are within us as indigenous people. It's a natural process that we navigate to when we're not well and when we need to heal ourselves. We have been very fortunate that we've had the University of Alberta come into our community to do research with our diabetics. We've had several doctors, and Dr. Winterstein is going to be starting in our community to do specialized work with diabetics.

Long-term care is an area. Our elders need to have a place where healing is going to continue, where it's dignified and they're in the surroundings they grew up in. They want to feel that comfort. They talk often of not wanting to leave the place where they were born, where they taught their children, and where they themselves learned as children. They want to be able to remain on that land. The minute they hear that they need to travel away from the community to a long-term care facility, you often see that look in their eyes where it just comes to a halt, where they don't want to leave. To them there's no sense in going forward, because it's not a dignified death or way of healing for them.

● (1625)

The Chair: Thank you.

Ms. Florence Willier: It's very important that communities like ours in Driftpile...we've done the studies; we've had doctors; we've had professors; we've had specialists who have done the stats.

I really appreciated when Chief Bellegarde stated that they've had stats done. We've also done that.

The Chair: Thank you so much for answering the question, but we've run out of time.

To all of you, on behalf of the committee members, we want to thank you for participating.

[*Translation*]

Thank you very much.

[*English*]

Meegwetch.

You're welcome to stay. We're going to have another panel and continue the information sessions after this. We'll take a short break.

● (1625)

_____ (Pause) _____

● (1635)

The Chair: Welcome, everybody.

We have three presenters in this panel.

We have with us from the Sioux Lookout First Nations Health Authority, John Cutfeet, and from the Nishnawbe Aski Nation, Deputy Grand Chief Derek Fox.

Derek and John are here in Ottawa.

Then we have Heart River Housing, which is by video conference, and then Chief Delorme.

The way the agenda is lined up, we are starting with John Cutfeet, board chair, and Deputy Grand Chief Derek Fox.

Does that work for you?

Deputy Grand Chief Derek Fox (Deputy Grand Chief, Nishnawbe Aski Nation): We were going to reverse the order, if that's okay with you.

The Chair: I go with the flow. It's all right.

You have 10 minutes. I'll try to give you a signal if we're getting close. After everyone presents, we'll have some questioning from the members of Parliament. Please go ahead.

Deputy Grand Chief Derek Fox: Good afternoon, everyone. My name is Derek Fox. I'm deputy grand chief of Nishnawbe Aski Nation. My home is Bearskin Lake First Nation, the community that is the second-farthest north in northern Ontario.

For those who don't know, Nishnawbe Aski Nation makes up two-thirds of the Ontario land mass. We have 49 first nations and 50,000 people, and we have 32 remote communities. Many of those people would tell you that we're the remote ones, not them. They're very proud of their homelands. They're very proud of the makeup of their homelands, the river systems, the muskeg, and the swamps. It's home to them. It's home to us. It's home to all of us.

Before I forget, I would like to acknowledge my colleagues who are here: our health director, James Cutfeet, and John Cutfeet, who is a man of many talents.

As you know, we're here today to talk about elder care. Our theme is, "I want to go home". The main concept, idea, and vision is for our elders who want to go home, who want to spend their last years at home, within their lands that I just spoke of. We don't want to see them lonely and sick. I'm sure many of you can relate. Many of you have parents and many of you have had grandparents, and you wanted to ensure that their last years were comfortable and they weren't lonely.

I know we only have 10 minutes. The basis of this presentation is going to go to John Cutfeet, so I'll pass it over. I just want to say *meegwetch*, and thank you for having us here today.

The Chair: Thank you. We will be coming back to presenters during the question period.

John Cutfeet.

Mr. John Cutfeet: *Meegwetch.*

[*Witness speaks in Oji-Cree*]

Thank you. I greet you, all.

I'm from Kitchenuhmaykoosib Inninuwug. It's about 600 kilometres northwest of Thunder Bay. The English name for it is Big Trout Lake. It's a beautiful place, a beautiful spot. It's very hard to leave that place, so you can imagine how our elders feel when they have to leave home to go to a long-term care facility away from what they're used to.

I have a small presentation that I'll read to you, but before I do that I would like to mention our health policy and advocacy director for NAN, James Cutfeet. We're related, if you haven't picked that up by now. He's my brother.

Voices: Oh, oh!

Mr. John Cutfeet: As the deputy grand chief mentioned, the title of our presentation is "I Want To Go Home".

When care and the associated provisions of health services become unavailable, our eldest must leave their home communities to be institutionalized at urban long-term care facilities. Their new surroundings are unfamiliar. The elders strive to adjust in their new settings, but they yearn to be home with family, amongst their grandchildren, the familiar surroundings of their community, to be able to speak in their own language, and to be able to commune with the land they're familiar with.

When at long-term care institutions, the phrase we most often hear of the elders is, "I want to go home." It's a simple request coming from our elders, yet impossible to comply with. Why is that?, you may ask. In our presentation we'll provide you, the members of the standing committee, information regarding the challenges that prevent us, as first nation leaders and health practitioners, to fulfill our elders' requests of "I want to go home."

The deputy grand chief gave a bit of a background. The Nishnawbe Aski Nation represents 49 first nations out of the 133 first nations in Ontario. it comprises two treaty areas: Treaty No. 9, and it also straddles Treaty No. 5 within Ontario. Geographically, NAN is the size of France. Thirty-two of the 49 first nations are remote access only, and accessible by air year-round. Road access to the 32 remote communities is usually available by winter road for about four to six weeks, depending on the climate change phenomenon.

On July 23, 2017, Nishnawbe Aski Nation signed the Charter of Relationship Principles governing health system transformation in Nishnawbe Aski Nation territory, with Canada's Minister of Health at the time, Jane Philpott, and Ontario's Minister of Health and Long-Term Care at that time, Eric Hoskins. The principles outlining the transformation of health and its design will be determined by the people of NAN through community engagements, which are very critical. It is highly expected that elder care will be one of the priority issues raised during the community engagement process. The topic of elder care was first presented at a NAN assembly 17 years ago. Now the cause is being renewed to address elder care in NAN communities.

The care of our elders is largely done by family members who often take turns providing care to their aging elders, and do so without formal training or essential supports. Respite care does not exist in any of the communities to provide relief to family caregivers. The only time relief comes to family caregivers is when the aging elder is admitted and sent out of the community to an urban hospital. This usually happens when the elder's care needs can no longer be met in the community as only basic assistance is available, or because the family caregiver's health is failing due to the neglect of their own well-being and the family caregiver is no longer able to provide care.

● (1640)

A minimal amount of home care support exists in NAN communities. We say this because provincial funds were increased this fiscal year to all 133 Ontario first nation communities. However, it is not enough, and culturally safe human resources remain a challenge. Qualified personal support workers are scarce in the communities. The workers assisting elders in the NAN communities learn on the job, unlike the PSWs in urban long-term care institutions who must be certified.

Home care support in first nation communities is only offered Monday to Friday, 9 a.m. to 5 p.m., weekly. On weekends, it is the family caregiver's responsibility to provide care. There are numerous challenges associated with the elders saying they want to go home. There are jurisdictional issues and underfunding. First nation needs are often caught between the responsibilities of the two governments, and entanglement continues due to the federal division of responsibility: Indians and lands reserved for Indians. Long-term care beds do not exist in NAN first nation communities. The recent provincial approval of 106 long-term care beds is for urban institutional settings. Two hospitals will receive 76 and 30 long-term care beds within the NAN territory.

Home care support, as mentioned earlier, is lacking and fails to address after-hours monitoring. On occasion, when elders suddenly pass from this world in their homes and apartments, they're not found until the next day.

I only have two minutes, so I have to move forward. We've outlined some points and put information in this research document for you to read later about some of the things that are required in the communities to improve access to services. Due to the social determinants of health, barriers to health services, and a number of other factors, there's a need for long-term care homes in first nation communities, because a majority of these homes are, as I said earlier, in urban settings, and that's where we have to send our elders when they can no longer have the care that's required in the community.

Recently, when we had a meeting with our leaders just these past few days, we heard comments from Chief Lorraine Crane of Slate Falls Nation that their elders want to stay home with their families. Chief Ignace Gull from Attawapiskat First Nation says their elders are a priority, and there is no medical support, and that should be a priority. Chief Wayne Moonias from Neskantaga First Nation says that elders have challenges while in urban care and that they would not treat our elders the way they are treated.

There are concerns with the care our people are receiving. Our elders are often returned home in a coffin without an explanation of how they died. How many more elders will we lose before the plan is done? It saddens us when our elders are sent out to homes that are not culturally appropriate and families are disconnected. That's why it is very important that we focus on the requests of our elders to respect and to maintain the dignity of our elders when they say, "I want to go home".

That's the theme of our presentation, and I thank you for the opportunity to let us speak with you today.

Meegwetch.

● (1645)

The Chair: Our next presenter is Lindsay Pratt from Heart River Housing.

You have up to 10 minutes.

Mr. Lindsay Pratt (Administrator, Heart River Housing): I'd just like to take the opportunity to thank you for allowing our voice to be heard from out here, and hopefully any information I can give can be of some assistance to you guys.

Basically, Heart River Housing is a non-profit management body established by the province to manage low-income family housing, provincially owned buildings and lodges. We are not, generally speaking, in the health care business. We do have four lodges in our area.

Our area runs from the community of Fox Creek, Valleyview, all the way down to High Prairie and Slave Lake. Most of our communities are under 2,500 people, so again, we're a very small, spread out area. I think we cover over 40,000 square kilometres of area within our region.

We are also very close to five first nations and three Métis settlements that call High Prairie and Slave Lake their main trading centre, so we do have lots of interaction with the first nations in our region. Eighty per cent of our family housing units have indigenous families in them, so again, our record of working with indigenous families and peoples is really, I think, very good.

On the seniors side, we are seeing more seniors coming into our lodges, who we are trying to accommodate on the cultural side, but again, right now there is not that.... We are concerned about why they are not coming in. I do understand the concept of not leaving home and I can appreciate everything that Mr. Cutfeet has explained about seniors not wanting to leave their supports, although our communities are very close with the bands and the settlements, and I think there is a bit more flexibility in that area.

On the long-term care side of things, the community of High Prairie just had a 64-bed long-term care facility built. They had talked about it taking up to five years before it would be full and it took about three and a half months until all the beds were full. Again, that puts a lot of pressure back on the seniors lodge facilities because we are delivering level 2 care to our facilities. We would be open to delivering level 3 care in a more home-type environment versus an institution. I can appreciate what my former colleague said about moving people to an institution-type setting. Our lodges are not like that. We consider them homes and we try to make them as comfortable as possible without having a hospital-type setting.

We manage about 900 units, and 175 of those are seniors lodge facilities. About 125 are seniors apartments. Again, our experience and our workload on the health side of things is not as deep as we would like it to be because we think we could be of more help.

I am going to cut my time short there and open it up for some questions after if I can be of some support.

● (1650)

The Chair: Thank you.

Mr. Lindsay Pratt: I should have told you that ahead of time and I could have passed my minutes on to somebody else.

The Chair: That's a lot of innovation all in one meeting. We'll have to see where that goes.

We're going to do the 10 minutes for our last presenter, Chief Delorme.

You have up to 10 minutes.

Chief Cadmus Delorme (Cowessess First Nation): Thank you, Madam Chair.

Cowessess First Nation is in the Treaty 4 territory. I see one of my colleagues, a tribal chief. Edmund spoke earlier. We're from a similar area.

Cowessess First Nation has 4,259 citizens. Just under 1,000 live on the homelands, and everybody else lives nomadically throughout Treaty 4 and beyond. Our average age at home is around 35, and we have a lot of baby boomers wanting to move home or living at home.

I have three quick stories which will give you more of a personal touch.

A man named Bruce who passed away in October got dementia about two years ago. He was a leader for many years in the community. He passed away when he was 69. In his last year he was admitted to Broadview Centennial Lodge, a residence about 23 kilometres north of Cowessess. He was a harmless person, but because of dementia, he had a few aggressive moments, unfortunately. Sometimes he would be tied to his wheelchair because the nurses didn't know what to do. He was trying to leave and stuff like that. It was very emotional for the family to see a loved one being treated like that. I have no disrespect for the lodge; I know they had very limited resources.

Bruce was conscious enough that he knew he wasn't at home on the reserve. Every day he would have that drive to try to get back home. All he wanted was to be back home. Unfortunately, the dementia got the best of him, and then he passed away.

The second story is about a lady by the name of Maggie Redwood. She passed away about a year ago. She was 101. Her family refused to put her in a home. She was at the stage where her family did everything for her. They changed her and bathed her. They pretty much fed her. The family got very fatigued in the last two years of her life, only because they had to sacrifice their own jobs and their own personal time. They refused to allow her to live in a home off the reserve. It took a toll on the family to honour their grandmother, great-grandmother, great-great-grandmother, but they allowed her to live out her days in a standard house on Cowessess, giving that stage 3 support from within their means.

The last one is Harold Lerat. He is currently with us. Harold thinks he's on the reserve, but he's in a home. You talk to him, and he says that his horses are outside, and his reserve house is there. It gets to the family once in a while when they have to go to Broadview again but they don't want to break his heart, and tell him he's not at home.

Those are three stories to start, given the need that long-term care definitely has to make its way back to the homelands.

In Cowessess we separate them into three age categories. The under 21 and the 22 to 54 have certain needs and wants in life. The 55-plus want two things. They want security and they want to know that someone's looking after them. Sometimes when you get to stages 2, 3, and 4, some of them will not say much because they don't want to fear getting removed from their house and put into a lodge. It's to the point where they will hurt themselves trying to pretend that everything's all right. The ultimate thing is they don't want to leave. They don't want to be looked after off the reserve. They want to stay home.

We have different categories. We have some in stage 2 that require some basic needs. Maybe they don't need to be in permanent long-term care, but definitely need something close to home where they could go on a daily basis, even if it's a nurse or constant updates and things like that. They still can maintain a basic life.

When it comes to emergency services when we talk about long-term care and the goal to get more on the reserve, you have to assess the emergency services, and how long it will take an ambulance to get to the reserve, how long it takes to find the location. We're being a little more proactive about it here on Cowessess First Nation.

The next one is partnerships. Reserves, first nations, and bands can't do this alone. On Cowessess First Nation we have neighbouring nations—Sakimay, Kahkewistahaw, Ochapowace. We're dealing with this long-term care thing together. We're discussing it and seeing how we can partner to have economies of scale.

● (1655)

Even beyond that, there are jurisdiction differences because the first nation is on status land. As my friend said earlier with respect to lands set aside for Indians, there's sometimes a jurisdiction issue when it comes to the province.

One thing Cowessess First Nation is doing is meeting with its provincial partners to let them know we don't need to talk about jurisdiction since we know we have differences, and to see if we can get some care on the reserve, respect jurisdiction, and try to figure it out. Those conversations are starting to happen.

Cowessess First Nation has citizens who are RNs and LPNs. They have the qualifications. Some are working in the local lodges in the cities. The human capital is already there, and they're ready to move home.. It's just a matter of getting a little more overall capital infrastructure, if that's the goal.

I go to the home quite regularly just to visit, and many people there, first nation and non-first nation, are forgotten. Some of them don't get visits and some get very few visits. When you walk into a long-term home, they're so excited to see you. They all want to talk to you. One thing Cowessess does is hold a local powwow at the Broadview Centennial Lodge just to bring a little bit of culture to them and get them visiting.

One of our action plans is to have a long-term home on Cowessess, and we have it in our plans to put a day care with it. When it comes to seniors, one of the best medicines is their grandkids, great-grandkids, and children. To have a long-term care facility in the same building as a day care, where our next generation is getting primed up to be leaders, provides a balance and interaction between the two.

Sometimes there's culture shock when seniors have to leave the reserve. When you have a certain lifestyle and you maintain a certain character, whether it's humour or intergenerational trauma if it's related to residential school, there's culture shock. Sometimes in these provincial areas, nurses who are taught to deliver services are sometimes not taught the cultural awareness. That culture shock means a lot, and I notice it's also something that has to be included.

I can't figure it out, but the reality is that a senior in long-term care has no problem being buried at home or finding a final resting place, but when it comes time for those last five years of their life, they are not allowed to be on the reserve because we don't have the services. There's something not correct in that area, and I know that when we put all our minds together, we can figure it out.

Finally, I just want to say that I'm really excited to be a part of this. I want to end off by saying that it's not just about long-term care of our seniors. Cowessess also has some adults in stage 3 and stage 4 who live with their grandparents, and to some degree it's elder abuse because the elders don't know what to do with their grandkids. I know this may not be the committee that talks about that part, but I just wanted to throw that in there. When it comes to stage 3 and stage 4 long-term care, there are others on Cowessess who aren't elders and whose situation also needs to be addressed, so we need to figure this out. We can't forget that younger generation.

Thank you.

● (1700)

The Chair: *Meegwetch*. That's a very good point, and it is part of our study, for sure.

Now we're moving on to the questioning, and we are going to start with MP Mike Bossio.

Mr. Mike Bossio: Thank you, Chair.

Thank you all so much for being here today.

As a committee, we had the benefit of going to Sioux Lookout, and we were treated very well, I have to say. It was a tremendous experience during which we were introduced to a lot of different services provided at the hospital, at the elder lodge, and by the health services branch.

I have to say that the biggest impression I was left with when we departed was the burnout rate of your PSWs and health service personnel. When we met with the health authority, that was one of the messages I came away with, and by the sounds of what John was saying, it hasn't changed.

It sounds like a multi-faceted issue in that there's a shortage of available people with the right skills to provide the services, and there's a shortage of training and skills development when trying to train individuals as quickly as possible to deliver on those services.

Is the shortage within the community itself? Are a number of health professionals being brought into the community, or are we now finally reaching the point where we're training people within the community to deliver on those services?

Deputy Grand Chief Derek Fox: I'm going to have James answer that question.

Mr. John Cutfeet: As we move forward in undertaking our health care, one challenge we have is human resources capacity. One way of addressing that is to build and refresh the existing capacity we have on the professional side. On the other side, we undertake more programming to try to develop professionally designated first nations people.

The other challenge in getting people into the community, to live in the community, is the accommodation side. You probably have heard numerous stories about lack of housing. That is going to be compounded as well, because we will need professionals and resource people to be in our communities.

Yes, human resources development is a major concern at this point in time, and we need to start addressing how we're going manage that.

Mr. Mike Bossio: It comes back to what we've heard in so many different sites we've done, which is about the social predeterminants, starting with education. If we don't have the education to train individuals, not just in health but as carpenters, electricians, and builders, what we need to do goes all the way down the line, because we need to build houses. If we don't have houses, then we can't bring in health professionals, but we also need to train those health professionals to make them available. It always becomes much more complicated than simply saying that if we just had more health professionals we could actually deliver on these services. The challenge is getting to that point.

I wanted to see if this is making a difference. Sioux Lookout First Nations Health Authority recently secured funding for a mobile indigenous interdisciplinary primary care team. Once implemented, how will this service support long-term care needs in the communities you serve?

● (1705)

Mr. John Cutfeet: Once it's operational, the mobile unit will be helpful. Again, to have professionals go into a community en masse, the challenge is how we accommodate them all.

When I was in Big Trout as the chief of the community a year ago, we were fortunate to be approved for a new health centre. We urged the federal government, Health Canada, to expand the office space, especially the exam rooms that are needed. We have nurses who are on site, and then we have doctors coming in and other visiting professionals who need rooms. At least we're trying to see how we can expand those facilities as new ones are being approved for construction in the communities.

Mr. Mike Bossio: As part of this mobile unit team, there's a lot of infrastructure that needs to be in place in the individual communities so that these teams can even just deliver the services in the first place. In your view, how could long-term funding arrangements lift barriers related to first nations communities' capacity to provide long-term services and facilities? How could long-term funding arrangements offer first nations communities greater flexibility and autonomy in providing relevant long-term care services?

The Chair: To whom are you directing the question? We have someone on video conference.

Mr. Mike Bossio: To James once again, just because we have familiarity, with the experience of having visited there, with what's going on.

Mr. John Cutfeet: Again I'd go back to that health facility that was approved at Kitchenuhmaykoosib Inninuwug, Big Trout Lake. One question I raised was how we could include the province and how we could get provincial capital to come onside, so that we could have a bigger facility and accommodate provincial and federal programming.

The two capital processes do not coincide with one another. There needs to be some kind of discussion by the two levels of government to have that happen. Even if it's a one-off federal conversation for funding, for capital, they'll say, "That's the province's responsibility. We will not entertain that." There needs to be a collaborative discussion between the two levels of government to see how we can merge the financial capital together so that better facilities can be built in first nations communities.

Mr. Mike Bossio: Thank you very much.

The Chair: Questioning moves now to Arnold Viersen and Kevin Waugh.

Mr. Kevin Waugh (Saskatoon—Grasswood, CPC): Okay, here we go.

I'm going to go off on yours. I would see three levels. I would see the federal, the provincial, and your community. When you talk about health care, you talk about nothing but waste in this country. I've just come from the province of Saskatchewan where we ditched 32 vice-presidents of whatever. We've gone to one health authority in my province. We used to have 32. We're down to one. They scrapped all the vice-presidents.

We've just had an interesting conversation with Chief Bellegarde on this. Let's start with the amount of money that is being wasted provincially, and I would say federally in administration that doesn't get to where it needs to go.

I'm going to, first of all, go to the Nishnawbe because you did talk about the federal government and the provincial government but I would say they should also include your group. I don't know where this conversation has to start on partnerships, but it's one that this country (a) cannot afford, and (b) must move very quickly on, because long-term care, whether it's in an urban resource, in an urban facility, or a reserve, is deplorable in this country.

Start with that, if you don't mind.

● (1710)

Mr. John Cutfeet: One thing that goes on in first nations communities to try to accommodate elder care is that first nations do seek financial resources to build facilities. What you're saying is, yes, there's the federal government, there's the province, and where's the first nation, that we can use the meagre resources we have to partner-up to build a better facility.

It's like my home community of Kitchenuhmaykoosib Inninuwug. They've amortized senior facilities to make sure that they have at least a place where they can accommodate seniors.

Mr. Kevin Waugh: Yes. Good.

I have to go to Cadmus. Good to see you again, Cadmus. I want to congratulate you on all the work that you have done in your community since you've become chief. You've done a wonderful job on education and you have great ideas for your elders. Now let's maybe talk about the one health system in our province.

Does that affect you right now? Have you seen any changes since they brought it in a few months ago?

Chief Cadmus Delorme: Thank you. It's like a new relationship. It's still in the lust area. We don't really know how to go about it yet. The new one health system is only, I believe, four months old, somewhere around there. We have met with the health authority. We met with the Ministry of Health. When I go to those meetings as a chief, I feel like them too. They're still feeling out their new role with one another in regard to the political aspirations and the public [*Technical difficulty—Editor*]. I think it's a move that has economies of scale.

On the new board, there is, I know, a minimum of one indigenous person. I think they could have addressed that a little better because you don't really know the indigenous issues unless you're an indigenous person. I'm optimistic about it. When I go to those meetings, what we say from Cowessess is that we have one thing in common: we share this land together. We disagree on jurisdictions. Let's leave that conversation to when we need to talk about it. Let's just talk about getting some services between Cowessess and the Province of Saskatchewan.

I feel that we're at the point where I have to ask the province, "Are you in or are you out?" I feel like we spin our tires at those meetings because they keep saying, "Well, we have to hand it off to this person. We have to hand it off to that person." We bring the papers, we bring the idea, but no one wants to stamp it.

Mr. Kevin Waugh: I'll hand it over to Arnold Viersen now.

Thanks very much.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you, Lindsay, for being here today. I really appreciate it.

I come from northern Alberta. Your organization would deal with a lot of first nation spillover into your communities. Have there been any talks about bringing Heart River Housing facilities to reserves?

Mr. Lindsay Pratt: No, we have not at this time, but the province is coming out with an indigenous housing program, and I know that there's some CMHC funding available. The town of High Prairie is planning on starting some discussions with the first nations in the surrounding area just to kind of open up the dialogue, because the other thing that we don't understand is what is happening to their seniors now. Up until now, we've kind of just stayed in our little silo and done what we've done, and if people come to us, we serve them, no matter where they come from, but I think it's time for us to reach out to those reserves and settlements and ask, "Where are your seniors going now? What plans do you have for them, and how can we help facilitate that?"

If their facilities are built in our communities, how can we make them culturally acceptable so that they feel comfortable moving in and out? I know the surrounding communities of the first nations and the settlements are very small, so again, you get into the economies of scale and how they can work that out, and it's very difficult for them. Any help that we can be.... Our doors are open. Our board is very proactive in that, and I know the town of High Prairie is starting to look at that. Those are opportunities to move forward.

● (1715)

Mr. Arnold Viersen: I know that several of the first nations in the surrounding areas have reached out to me to build their own facilities. Would Heart River Housing be interested in participating by bringing some expertise and building those facilities?

Mr. Lindsay Pratt: Absolutely. Anything we can do.... Again, we can help them where they are now or they can come to us.

Our biggest problem right now is, again, provincial health. They just built a new hospital in High Prairie with 64 long-term care beds, and they're already full. What happens is that level 3 care, where those individuals might come off the reserve and should be assisted in that community, in that hospital, and in that long-term care facility, but are getting pushed back to the lodge or pushed home where the families don't have the facilities to take care of them properly. Again, you run into those situations where the families are trying to do the best they can without the proper resources. If they are going to be pushed back home, then let's support those families doing it on reserve or on settlement. If not, let's give them an opportunity and a place to go.

Mr. Arnold Viersen: Thank you.

The Chair: That ends our time for you, Arnold. I'm sorry. It seemed short. You'll have to talk to your partner.

MP Rachel Blaney.

Ms. Rachel Blaney: Thank you, Chair.

Thank you all so much for being here today. I really appreciate what you're sharing with us.

I will start with the Deputy Grand Chief, James, or John, whoever would like to speak.

One of the things that we've heard repeatedly through this process is a list. One of the challenges is a lack of adequate data. There are challenges in the realities of multi-jurisdictional frameworks and the lack of funds to build the infrastructure for long-term care homes. There are the challenges of rural and remote communities, which I know that you know a lot about, and the core need for connection back to the community. The last thing is training and human resources.

When you share your stories about those challenges and the theme that you share with us, which is, "I want to go home", could you tell us a little bit more about what it means to be in your community? How remote are you? How long does it take to get to the nearest care facility, and what are some of the challenges your people face in making that work?

Deputy Grand Chief Derek Fox: I can answer that.

As I mentioned earlier, we have 32 remote communities and 49 altogether. You asked us about what conditions are like. As Mike alluded to earlier when we talked about the social determinants of health, I would say that 90% of those would make up our issues. You're talking about education, infrastructure, and social challenges. All these things combined lead to health issues, whether they're for youth, elders, our people, and so on.

I've always believed that we should be investing in those things, including infrastructure, programming for our youth, recreation, hockey, spending time on the land, and being proud of who they are as first nations people—whatever we have to do to ensure they're healthy and that they're raised right.

People in our 32 remote communities all need to fly out to Sioux Lookout or Timmins. A return flight would cost about $1,000 to $1,500. They have to go through the non-insured....They have to pick up the phone and call non-insured, which has to approve them. Sometimes they say no. Sometimes they say yes.

They come into Thunder Bay and Sioux Lookout and have to spend time there. Some of them can't speak the language. They get lost in the city. They get lost in the town. It's a whole process to be leaving their first nation to go to a town in which they're not comfortable and having to survive just to get health care. That's the reality of seeking health care for our people.

As I said, you raised some very good points about the social determinants of health. If we could address those social determinants, we'd all be better off. When the health care issues arise, you find that the federal government or the provincial government, whoever it may be, is bailing out first nations or assisting the first nations with health. If we just invest in the foundation of a first nation, we can try to prevent those crises we see. That's it in a nutshell.

● (1720)

Ms. Rachel Blaney: One of the things you also talked about is caregiver burnout, how exhausting it can be for families and how little support there is. I've heard that there is home care during the week from nine to five, but not during the weekend. Is that just underfunding from the government? Can you tell me a bit about what that breakdown is?

Mr. John Cutfeet: Thank you for that question.

The funding for home care is very limited. In our own community, for whatever is funded there, the number of clients they have has grown, yet the funding hasn't. That's one of the issues.

We said that there is caregiver burnout or that a caregiver's health is failing. I was one of those. While I was chief, I was also looking after my mother. The routine, I used to say to keep my siblings informed, was Mom's been watered, fed, drugged, and the door locked. It was the reverse of that in the evening. To do that day in and day out, seven days a week...yes.

When I took my mother home in February 2017, she lasted until August, when she had an accident in her apartment and was no longer able to be by herself. She was removed. There was nobody there to offset my need. Nobody volunteered or even said, "We'll pay you."

Ms. Rachel Blaney: For your community—or communities, really—is there one place where you're thinking of having a care facility that everybody would access? Do you have a particular model in mind for long-term care?

Mr. John Cutfeet: My son is a physician in B.C. The population of the community is about 1,800. They have a small hospital. They have 10 eldercare beds. One of the thoughts we have is, why not have hub models, where at least the elders can be in a native setting, in a native community, where they can use their language and have some company? A hub model is one of the aspects we're looking at.

Ms. Rachel Blaney: Thank you.

Deputy Grand Chief Derek Fox: To give you an example of the hub model he was talking about, we have 32 remotes. We have larger communities and we have smaller communities. What if Webequie, for instance, had the main centre and we had other elders from other areas going to Webequie? It might not be "home" home, but they're in the north: they're home.

That's what he means by hub models.

Ms. Rachel Blaney: It's similar language.

Deputy Grand Chief Derek Fox: It might be just the bigger communities that have the capacity to do. I know that capacity is another issue, as is land. I know that in Attawapiskat they can't build any more houses because there's no land. They're working with the federal government to get more land so that they can build more houses.

That's another issue when we talk about the social determinants of health care.

Ms. Rachel Blaney: Thank you.

The Chair: We'll end with our new member, a guest with us, MP Churence Rogers.

Mr. Churence Rogers (Bonavista—Burin—Trinity, Lib.): Thank you, Madam Chair.

The Chair: You're a long way from the Prairies, from where you are.

Mr. Churence Rogers: Pardon?

The Chair: These folks are kind of prairie people, and you're from the Rock.

Mr. Churence Rogers: Indeed. I was about to say that I empathize with the people living in the north and rural areas. I come from a very large rural riding in Newfoundland and Labrador, and many of the challenges identified today are the challenges that people in my communities face.

There are many different models in play in Newfoundland and Labrador. One is a home care model where they have people hired to go in and live with some of these elders and seniors for long periods of time during the day and evening. That's been pretty successful. They have been able to keep people in their homes until the very extreme period when they have severe dementia or some other issue and have to be placed in long-term care in an institution.

Mr. Delorme, you mentioned some of the partnerships that need to be created as possible solutions for dealing with some of these seniors in our communities. The partnerships, I would assume, would include the federal government as well. What do you see as the role of the federal government in that partnership?

● (1725)

Chief Cadmus Delorme: Of course, the purse and the wallet right away would be an automatic need. For example, at Cowessess First Nation we talk with our surrounding first nations of Sakimay, Kahkewistahaw, and Ochapowace. We respect our own jurisdiction, but we realize that we have to partner in certain services. This is one of them.

One thing we discussed is why we don't have one on the four reserves? We talked with some of the surrounding towns. The beds have waiting lists. We said, well, why we don't we build a 20-facility stage 3 and stage 4 seniors centre on Cowessess? We'll open it up to anybody. You don't have to be from the four reserves. You don't even have to be first nations. It will be on Cowessess First Nation and it will be indigenous-centric, something similar to what we have in Regina with First Nations University of Canada. Anybody in the world can go there for higher learning, but when you're at that university, it's indigenous-centric.

In terms of bringing in a stage 3 and stage 4 seniors facility, we talked with the province, saying that if the federal government could fund us with the capital to get this going, and we put in what we could, would the province come in and do the day-to-day administration costs? We wouldn't be able to handle that. Surrounding first nations, such as White Bear, I believe, have tried it. Standing Buffalo is doing it. We have realized that because of the unique jurisdiction, the province has to play a key role. Once it's completed, then we move forward.

Mr. Churence Rogers: Thank you very much. That makes a lot of sense to me.

I know that there are numerous examples from across the country in rural parts of Canada where they have tried different models in different jurisdictions and so on.

Mr. Cutfeet, Sioux Lookout First Nations Health Authority recently secured funding for a mobile indigenous interdisciplinary primary care team. Once implemented, how will this service support the long-term care needs in the communities you serve?

Mr. John Cutfeet: Which Mr. Cutfeet...?

Voices: Oh, oh!

Mr. Churence Rogers: Oh, okay, whoever. Sorry.

Mr. John Cutfeet: The health programs that are starting to be put together to take a more collaborative approach will feed into supporting clients or patients across the spectrum, including elders. One of the issues that we do have now, especially in physician care, is we are only allotted so many days. Sometimes elders are unable to see the doctor even if it's an emergency, because the doctor's schedule is full.

Hopefully with that primary care mobile group, they'll be part and parcel of that to assist with the elders' care as well as support the doctors who go into the communities.

Mr. Churence Rogers: Thank you very much.

The Chair: We've run out time. We have about 30 seconds, if you feel compelled.

Mr. Churence Rogers: Okay, just for Lindsay, you offer both senior supportive living and self-contained apartments. What are the benefits of these models and how do you see the viability for that system on reserve?

Mr. Lindsay Pratt: With the senior self-contained apartments they get into a lifestyle, a little bit of a communal living. There can be some supports with other seniors yet they can still have the independence to cook on their own and do what they need to do.

With the lodge settings, they have their room cleaning and their cooking done by us, but they still have that independence where they can come and go as they please.

With the health care that the province brings into our facilities at a level 2 care, it's basically scheduled care. Again, you get your pills on time and those kinds of things. For lots of the seniors who come to us, it is really a stabilizing opportunity. They've lived in their homes alone; they're lonely and they don't take their meds on time. Things snowball.. When they come to our facility, they're able to stabilize themselves and it really adds some years to them. The other thing is they get to visit with other people every day and still come and go.

● (1730)

Mr. Churence Rogers: It's important.

The Chair: It's important.

John. Okay, something very profound....

Mr. John Cutfeet: I think in the greater picture, one of the things we would like to see happen at the community level is we stop taking people out. As you are aware, in the history, children were taken out. Currently, under the child welfare system, children are still being taken out, and then the elders are being taken out. We would like to put a stop to that.

The Chair: I know in Manitoba, there's like 60% to 70% of the people who have left the res. How many of those people want to come back home? Is it 50%?

Mr. John Cutfeet: I can't say anything for Manitoba, but for our community—

The Chair: Go on, you could so. You're neighbours.

Mr. John Cutfeet: No, I don't speak for the people of Manitoba, but I can speak for the elders who we recently have spoken with.

The Chair: Okay.

Mr. John Cutfeet: This one elder is looking after his wife who is ill, and he said, "If I get sick, I'm not going to be able to look after her. We're going to be taken out." What I would like to see is a long-term care facility in the community and for other elders to have the same view I'm watching right now, the lake and everything that they are familiar with.

Meegwetch.

The Chair: *Meegwetch.* Good night, and have a great time in Ottawa.

The meeting is adjourned.

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